Medicaid Waiver Provider Orientation Outline

(For MW Expedited Providers)

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Medicaid Waiver Provider Orientation Guide
Revised: March 27, 2008

I. FREQUENTLY ASKED QUESTIONS

A. Role of AAAD

1. Primary contacts

AAAD is your primary contact for any issues about the Medicaid Waiver program. Any questions that you have should be directed as follows:

- For questions regarding a consumer you are servicing, contact the Case Manager for that person.

- For issues or questions that are provider related (i.e. expansion of service delivery area, annual monitoring visit) contact _____ at _____.

- For any billing issues contact _____ at _____.

2. Annual monitoring process

A monitoring visit is required annually and will be scheduled and conducted by AAAD allowing your agency time to prepare. There are some differences between the paperwork completed for your application and the document completed for your annual monitoring visit. The information provided are some items that your agency should be aware of. The following items below will be reviewed along with others during you annual site visit by the AAAD. Also, if your agency is providing services throughout different AAAD, only one AAAD will monitor your agency for the fiscal year, unless there are specific issues in another AAAD.

<u>Personnel</u>

- Employment application including section to list prior convictions.
- Evidence of employment history checks for all personnel.
- Evidence of reference checks for all personnel.
- Current job description in each chart.
- Confidentiality statement in each chart.
- Annual influenza shot or signed declination.
- Completion of all relevant criminal background checks, including sexual offender registry check and abuse registry checks (completed in both name and social security number).

<u>Training</u> – Refer to chapter 13 of the Medicaid Waiver Provider Manual

- Evidence of 12 hours annual training curriculum and implementation (current to date with monitoring visit).

- Documentation of adequate orientation training.

Service Delivery

- Services are provided within five calendar days of authorization notification.
- Services and units of service delivered are consistent with those ordered by the authorizing agency in the form of Plan of Care and according to the unit rates specified by contract.

Records and Reports

- When more than one type of service is being provided the agency makes clear the distinction of each service on their billing.
- Documentation is present of each service provided with each visit, which include a services rendered checklists this is signed by the enrollee and the worker.
- Each enrollee chart include at a minimum the following:

-Basic client information
-Service authorization
-Signed release of information
-Plan of Care
-Progress/Case/Contact notes
-Daily Log sheets (to document services)

Quality Assurance Review Procedures

- Evidence of adequate and timely incident reporting and missed visits reporting, including the training of these issues to employees and volunteers.

GNRC-AAAD adopts all TCAD's program manual policy & procedures and for more information you may contact _____.

3. Provider meetings

The AAAD Network of Providers meet on a quarterly basis and the dates are:

B. Receiving Your First Client

1. Client's freedom of choice

The time that you will receive your first client will vary. Keep in mind that the selection of your agency as a provider is driven by client choice. When you become an approved Waiver provider, your name will be added to the list of other Waiver providers in your area. Consumers will be able to choose you as their service provider or any other approved Medicaid Waiver provider who serves the same counties and provides similar services.

2. Notification of new clients

The way that you are notified that a client has chosen your agency varies slightly throughout the different case management agencies (listing enclosed). The typical process involves an advance phone call from the case management agency allowing the provider time for you to work on staffing for the case. **Providers are responsible for having adequate staffing plans to meet the needs of clients, which includes potentially delivering services on weekends, holidays and to cover when workers call off for the day.** Once the client has received all of the necessary approvals and services are ready to begin, then the case management agency will fax to your agency the following documents:

- Basic Client Information (BCI) - provides all the demographic information for client.
- Provider Notification - provides the information pertaining to types of services and frequency. **PAYMENT REIMBURSEMENT WILL NOT BE APPROVED IF SERVICES ARE RENDERED BEFORE START UP DATE ON THIS FORM.**
- Tasks Assignment Sheet- provides specific information about services being provided.

C. Billing Process

Each month, you will receive a blank Invoice for each service. The invoice includes each of the services provided by the provider. Invoices are e-mailed to the provider by the ___ working day of the month. The provider must return the completed invoice to the AAAD by the 10th working day of the month. The invoices may be faxed _____or e-mailed but the original signed invoice must be delivered or mailed to the AAAD. Emailed PDF invoices that are signed will be acceptable.

When the invoice is received from the service provider, the total units of services billed for each consumer is verified for the correct units billed and original signature before being approved and forwarded to TCAD for payment. Note: new clients may be added at the bottom of the invoice, but it is advised that a copy of the consumer's authorization be submitted in order to avoid delay in payment.

The area agency will forward the approved invoices to TCAD to verify and request payment from TennCare. In the event of denial of payment by TCAD, the provider should fax a copy of the denial to the AAAD fiscal department. The fiscal staff will review the reason for denial and contact the TCAD fiscal department to help resolve the billing issue.

TennCare has a direct deposit option called ACH (Automated Clearing House) that is available to all Medicaid Waiver HCBS providers. The advantage is that you will have access to your funds much sooner because you won't have to wait for a check to arrive by mail. There is a one page form for you to complete. Your contact person at the Area Agency will help you complete this form.

II. SERVICE DELIVERY

A. Services starting within five (5) days

SERVICES MUST BEGIN WITHIN FIVE (5) DAYS OF RECEIPT OF START DATE ON PROVIDER NOTIFICATION FORM.

B. Agency staffing plan requirements

We understand that providers need the flexibility to address appropriate staffing for new referrals and the case management agencies accommodate by providing the advance phone call to providers once the consumer has selected them to be their service provider, prior to all the final approvals for service to start. Continued declination of new referrals by the provider, will place the agency on suspension from receiving new referrals until the agency is able to show they have the capacity to service the entire county of the service area (s) identified, without any restrictions.

Keep in mind that many of these documents have the consumer's personal information (social security number, etc.) on them; therefore, all this information should be treated as confidential and filed appropriately. In-home staff should have access to documents on a need-to-know basis and only pertinent administrative staff should have access to this sensitive information.

In each enrollees home there should be a folder that is provided by their case manager/service coordinator and contains information such as:

- Emergency contact information
- Tasks assignment sheet
- Contact information (address and phone number) of the individual at **each** provider agency who is responsible for accepting information about incidents and/or complaints.

Your in-home worker can refer to this folder if a need arises.

C. Discontinuing Services

At any time if you determine that the Medicaid Waiver program is not working for your organization then you must complete this three-step process which involves submitting a 30-day notice letter to the following:

Step 1: Quality Assurance Coordinator
Address _____

Step 2: Provider Relations
State of Tennessee
Bureau of Tenncare
729 Church Street
Nashville, TN 37247-6501

AND

Step 3: Assist the assigned Case Management Agency in successfully transitioning your Medicaid Waiver clients.

III. Provider Reporting

A. Incidents/Complaints

All incidents and accidents of an unusual nature should be reported including, but not limited to:

- Suspected physical, mental abuse or neglect of an enrollee;
- Theft or exploitation of an enrollee;
- Report unusual incidents or accidents; and/or
- Specific complaints of a serious nature about in-home workers.

Complaints refer solely to the quality of service or lack of service. Complaint forms are submitted by assigned provider, Case Management provider, or by consumer filed due to failure to provide quality services.

Providers should instruct all in-home workers to notify their administrative staff/supervisor via phone as soon as the occurrence of an incident/accident is discovered. An Incident Report Form must be completed immediately and faxed within 24 hours to AAAD. Fax incident reports to _____.

B. Missed Visits

A Missed Visit Report Form must be completed for each reported missed visit by a Waiver Provider and faxed to the AAAD within 48 hours of the occurrence. Fax missed visit reports to _____.

IV. ADDITIONAL INFORMATION

A. Compliance with the Standards and Qualifications for services

B. Waiver Provider Manual

C. Sample Forms/Documents

1. Missed Visit Report
2. Complaints/Incidents
3. Provider Notification
4. Basic Client Information
5. Task Assignment Sheet
6. "Holiday Memo" from TCAD (see next page)

D. Case Management Agencies list

STATE OF TENNESSEE
COMMISSION ON AGING AND DISABILITY
Andrew Jackson Building
500 Deaderick Street, Suite 825
Nashville, Tennessee 37243-0860
Voice 615-741-2056
Fax 615-741-3309
TDD 615-532-3893

Nancy C. Peace
Executive Director

MEMORANDUM TCAD–PI–2007-07

TO: Area Agency on Aging and Disability Directors
Statewide Medicaid Home and Community Based Services Waiver Providers

FROM: Nancy Peace, Executive Director

DATE: June 20, 2007

SUBJECT: Provision of Waiver Services on Holidays and Weekends

This Program Instruction addresses the TennCare requirement that Waiver services must be provided in accordance with the enrollees' Plans of Care, including the provision of services on holidays and weekends, if prescribed.

Providers are contractually obligated to ensure adequate staffing to deliver services in accordance with the Plan of Care at all times, including holidays and weekends. If a service is ordered for six (6) or seven (7) days a week, it must be provided each weekend. If a service is ordered for five (5) days a week (Monday through Friday) or three (3) days a week and is usually scheduled for Monday, Wednesday, and Friday, care may not be interrupted if the scheduled service date falls on a holiday.

If an enrollee does not want a service to be provided on a holiday and/or the enrollee has requested that care be delivered on a different day, the request must be carefully documented. Any services not provided must be reported as missed visits with a clear explanation regarding the specific reason the service was not provided, regardless of whether the enrollee requested a change in service dates or whether the provider failed to meet his/her contractual obligation to deliver appropriate care.

cc: Grantee Agency Directors

(Standard reimbursement rate applies to work rendered on Holidays.)

SIGNATURE PAGE

Instructions: At the end of the orientation, please complete and return this page to your Area Agency and Aging and Disability.

Our agency, _____, has received the Medicaid Waiver Provider Orientation Guide and staff at the Area Agency and Aging and Disability has provided an overview of this document.

This signature page verifies that we understand all the enclosed information and agree to abide by the Medicaid Waiver Orientation Guide. I further understand that this Orientation Guide does not replace the need for a complete, agency specific, Policy and Procedure Manual. I agree to construct a Policy and Procedure Manual that is specific to my organization and have that document available for review during the first annual survey of my agency. Contractors that only provide the following services will not need to write a Policy and Procedure Manual: PERS, Minor Home Modifications, Pest Control and Assistive Technology.

Provider Authorized Signature:

_____

Print Name: _____

Email address: _____

Date: _____